“Thank you for giving me the opportunity to participate in this incredible program. Being part of the IRP program was by far the best educational experience I have had in my six years of university.”
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Introduction and Purpose

The Interprofessional Rural Program of BC (IRPbc) has provided an important first step for BC in establishing a collaborative interprofessional education initiative which engages numerous communities, health authorities and post-secondary institutions. Designed to prepare students for interprofessional and collaborative practice and promote rural recruitment of health professionals, the program places teams of students from a range of health professional programs into smaller British Columbia communities. The student teams experience the challenges and joys of rural life and practice, as well as advance interprofessional practice competencies in addition to discipline-specific skills.

The IRPbc is a collaborative provincial program, developed with funding from BC’s Ministry of Health Services and facilitated through the BC Academic Health Council (BCAHC). IRPbc represents a partnership between rural communities, health authorities, and post-secondary institutions across the province. Pedagogical guidance and leadership was provided through the University of BC’s College of Health Disciplines. Health Match BC, a provincial public sector recruitment agency for health professionals, provided the ongoing link to recruitment and retention considerations.

The goals of IRPbc are to contribute to:

- Recruitment and retention of health professionals in rural communities
- Modeling and evaluation of interprofessional learning,
- Expanding the capacity for educating health professionals in BC, and
- Ultimately, the program is expected to enhance the health of people living in rural communities

With the program underway for over 18 months, this report provides an overview of the program and its components; describes the evaluation through a program logic model; summarizes key themes from participant feedback; and makes recommendations for the future.
Background

January 2003

- Ministry-initiated proposal to develop a Rural Placement Program for BC – focus on interprofessional learning
- Designed to benefit:
  - Health Authorities – recruit & retain staff
  - PSEs – increase placement opportunities
  - Health professionals – promote lifelong learning opportunity
  - Students – foster interprofessional learning & practice ready
  - Rural communities – support quality care

GOALS AND OBJECTIVES IN PROPOSAL

- Increase capacity for clinical placements in rural communities
  - 3 sites, expand to more communities
  - Info to health authorities on best practices for student placements
  - Increase preceptor support
  - Increase support to HSPnet
- Make rural placements more attractive to students (e.g. incentives)
  - Establish criteria for incentives for students
  - Explore mechanisms for sustainable funding
- Link with other BCAHC initiatives to facilitate rural placements
  - Link with HSPnet and Preceptor & Mentor
  - Foster links with UBC Rural Training Program, Health Match BC
- Foster recruitment opportunities
  - Investigate opportunities to improve recruitment of allied health in rural communities
- Promote innovation for integrated health service delivery
  - Research & develop models on IPE and delivery of health care
  - Organize a series of workshops on IPE & research in the targeted communities to learn about best practices and share experiences

GOALS

- Model and evaluate interprofessional learning
- Expand capacity for educating health professionals in BC
- Support recruitment and retention of health professionals in rural communities and
- Ultimately enhance the health of BC communities!
Figure 1 (next page) provides an overview of IRPbc beginning with funding in February 2003 through to the completion of three phases of student placements in September 2004.
**Plan**

**IRPbc Implementation Team**
- Rural Communities
- Post-Secondary Institutions
- Health Authorities
- Ministries of Health & Advanced Education
- BCAHC

**IRPbc Goals**
- Model & evaluate interprofessional learning
- Expand capacity for educating health professionals in BC
- Recruit & retain health professionals in rural communities

**Implement**
- 5 rural community sites; 10 health professions; 8 PSEs
- 3 placement phases
- 12 student teams = 60 IRPbc students

**Evaluate**
- How does IRPbc influence competencies of students?
  - Broadening perspectives
  - Sharing knowledge
- What supports are required for rural communities to educate students?
  - Transportation, accommodation, IT, preceptor & student training and support
- What is the impact of IRPbc on recruitment and retention?
  - Tracking graduates that have returned to rural practice
  - Renewed energy in community

**Sustain**
- Consolidate lessons learned
- Build regional expertise across province
- Integrate IRPbc into the health & education systems in BC

**IRPbc Implementation Team**

**IRPbc Goals**

**Implement**

**Evaluate**

**Sustain**

**5 rural community sites; 10 health professions; 8 PSEs**

**3 placement phases**

**12 student teams = 60 IRPbc students**

**February 2003**

**Summer 2003**

**January 2004**

**Summer 2004**

**2004/05**

**Improved health care for BC’s rural communities**
The Implementation Team has provided the strategic direction and leadership in planning and implementing the IRPbc. The 25 representatives included front-line health practitioners, managers, educators, and policy makers from rural communities, post-secondary institutions, health authorities, Ministries of Health and Advanced Education, Health Match BC, and BCAHC. The Team has met monthly throughout the implementation process. It has provided a vital way to implementing the program quickly, keeping the process moving within short timeframes, enabling communication/interaction across participants and making program changes where required.

Each of the Implementation Team members has played a vital role in the implementation. In particular, the Program is indebted to the lead coordinators in the respective rural communities who have championed the program locally, and to faculty at University of British Columbia who have led the student orientation and developed the interprofessional competencies and student assignments. It has been a true partnership.

One of the key challenges of IRPbc has been balancing the perspectives across multiple post-secondary institutions, particularly given the central role of University of British Columbia with its leadership in interprofessional education provided through the College of Health Disciplines; its multiple health professional programs, many of which are the only ones in the province; and its interprofessional structures such as the Practice Education Coordinators Committee which were vital to establishing the processes within the very tight timeframes.

Nursing perspectives and placements have been particularly complex for the IRPbc given the large number of nursing programs in the province, and existing relationships with health agencies for various types of placements. It has been invaluable to have the Nursing Education Council of BC participate in the process, to foster communication with and input from the various nursing programs.
IRPbc community sites – number and type

IRPbc initiated three rural community placement sites for summer 2003 – Bella Coola, Hazelton, and Port McNeill, and then added two new sites – Trail and Fort St. John for January 2004. The number of community sites was primarily driven by an understanding reached with Ministry of Health Services, the source of funding for development and implementation. Given the provincial nature of the program, effort was made to geographically disperse the sites across the respective health authorities.

The decision to attempt to include medicine and nursing students in every interprofessional team shaped the choice of communities. It was opportune and expedient to piggy-back on the well-established Community Based Rural Training Program of UBC’s Faculty of Medicine. With their full cooperation, the first three community sites were identified based on their history and commitment to rural medical education, and presence of strong champions for the program. In the second phase, site selection was led by the respective health authorities in consultation with post-secondary institutions.

Phase 2 criteria for community selection were:

- Community provides full continuum of care – with integration across continuum
- Identified health professional to lead/champion the program in community
- Lead organization in the community has demonstrated commitment to education of health professionals (students, staff)
- Available preceptors for students across a range of professions who:
  - have the right qualifications
  - are interested in students and are willing to precept
  - are involved in interprofessional practice
  - can provide appropriate discipline-specific as well as interprofessional learning opportunities
- Able to support professions not represented in Phase I, such as midwifery, dentistry, audiology, counseling psychology, and others
- Can be mobilized in short timeframe
- Other criteria related to: available technology, infrastructure, specific recruitment needs, and broad community support

The five selected IRPbc communities vary in a number of ways, including size and remoteness. For example, Bella Coola has a population of 2,500, about half of whom are Aboriginal, whereas Trail has a population of 21,000 and is a regional referral centre. The type of community significantly influences the types of professionals available to precept and thus the potential composition of the interprofessional team. Phase 1 communities benefit from strong ties with medical undergraduate education and physician champions for the interprofessional interaction.

Each of the communities has had one or two designated health professionals who lead the program locally. In addition, three of the communities designated an administrative person to handle many of the logistics and schedules for students. The five communities have provided tremendous support to the development of the program and to the student teams. Students have consistently commented on the
incredible welcome and support they received, as well as the flexibility and creativity of rural health professionals, and the breadth of learning opportunities provided.
Background Research

In the early phase of the program, a literature search was undertaken, and several background documents were developed which set the stage and helped foster a shared understanding and vision for the program:

- Strategic Directions Working Paper highlighted key concepts and lessons from other jurisdictions
- Backgrounder on Interprofessional Education summarized lessons from other interprofessional rural programs and proposed approaches for the IRPbc including terminology, guiding principles, interprofessional competencies, team activities and evaluation
- Annotated bibliography

These documents were widely distributed and are available on our website www.bcahc.ca/irpbc
Student Teams

A number of key activities related to the interprofessional student teams warrant specific attention. They are discussed below.

STUDENT SELECTION PROCESS

The following student selection process focusing on community needs was developed through consultation with the Implementation Team and with post-secondary institutions in the province (through the provincial committee of Deans and Directors of Health Sciences, fieldwork coordinators, and others):

- Community identifies need/interest for students in particular education programs and provides preceptor contact information
- BCAHC forwards community requests to respective post-secondary institutions, through their fieldwork coordinators or other designated coordinators
- Coordinators process student applications as per the student selection criteria, contact the discipline-specific preceptor, and forward completed application for strong candidates to BCAHC.
- BCAHC receives/reviews/approves applicants from PSEs in partnership with the requesting communities.

Given multiple nursing and social work programs in BC, the following priority criteria were adopted for selecting students:

1. Traditional referring program in the geographic area (for nursing this is identified by the Nursing Education Council of BC)
2. Other programs in region
3. Programs outside the geographic region

In particular, IRPbc has endeavored to select senior level, strong students with an interest in interprofessional education and rural practice. Experience from other jurisdictions and from IRPbc to-date has reinforced the importance of these criteria, given the importance of active contribution to health care in the rural community and the interprofessional team activities.

COMPOSITION AND SIZE OF TEAMS

To date, eleven professions have participated in the program - medicine, nursing, social work, physical therapy, occupational therapy, pharmacy, speech language pathology, medical radiology, medical laboratory, counseling psychology and audiology.

Students have represented eight post-secondary institutions across the province including University of British Columbia, British Columbia Institute of Technology, Malaspina University College, North Island College, Okanagan University College (now UBC Okanagan), Selkirk College, University College of the Cariboo and University of Victoria.

IRPbc has endeavored to place four to five different professions including medicine, nursing and social work on each team. However, student teams have ranged from three students to seven on a team, and several have not had medical students.
There have been a number of challenges to team size, composition and interaction of the team:

- The composition and size of teams is influenced by a number of factors – health professionals to preceptor students (some communities have limited range of professions), type of health programs placing teams at one time, timeliness of the IRPbc processes to meet selection deadlines across multiple programs and the communities’ ability to accommodate/support students.

- Students typically arrive and depart from the community at staggered times according to their program requirements. In some cases, there is minimal or no overlap among some team members.

- Shift work by students (especially nursing) causes significant disruption to availability for student team meetings and activities.

**STUDENT ORIENTATION**

A two day orientation has been provided at the University of British Columbia for each of the three phases of student placements. The orientation has included content and team interaction focusing on personal learning styles, interprofessional team learning, rural health, aboriginal culture, working with victims of violence and boundary issues. In addition, health professionals from the rural communities have attended the sessions to interact with students and to talk about their respective community.

Participation at the orientation and feedback from students has been excellent. Unfortunately, medical students have been unable to participate to date given the timing of their examinations.

Although face-to-face interaction is very powerful, it is not sustainable to continue centralized orientation for students due to cost. It is recommended that the student orientation be shifted to an on-line format and cover both content and team interaction in advance of arriving in the respective communities.

**STUDENT SUPPORTS AND INCENTIVES**

Student incentives have decreased over the phases of the program as outlined below: In addition, students have been provided shared accommodation in close proximity to the hospital facilities.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Incentive</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Travel costs up to $800 reimbursed through receipts</td>
<td>Labor intensive/impractical to continue</td>
</tr>
<tr>
<td></td>
<td>One time award of $250 per week given the need to attract students and the effort by students in contributing to a new program</td>
<td></td>
</tr>
<tr>
<td>Phase 2</td>
<td>$800 for travel and other expenses</td>
<td>Sufficient to attract students, easy to administer</td>
</tr>
<tr>
<td>Phase 3</td>
<td>$500 for travel and other expenses</td>
<td>Sufficient to attract students, easy to administer</td>
</tr>
</tbody>
</table>
DEBRIEF SESSION

A two hour evening session has been held after each placement for informal discussion with students about their experiences. Among other questions, students were asked, for example: What was the most significant lesson? How will this experience affect your future professional career? What are your recommendations for the program and for future students?
Student Goals and Activities

Within the broader goals of the program, students were expected to:

- Develop an understanding of the roles of the members of the interprofessional team including such areas as professional boundaries and areas of collaboration.
- Develop an understanding of teams and team interactions.
- Share with others what they are learning in their placements.
- Provide and seek peer support in their learning experience.
- Identify and explore issues of common professional interest to their student team.

There was a number of skills the students were expected to improve or develop during their placement that related directly to IRPbc. These competencies were intended to complement skills needed in their professional practice but also involve understanding the “world view” of members of other professions. The assignments for the interprofessional component of the learning experiences of the students directly related to the competencies. The competencies were as follows:

- **Communication** This included developing an awareness of group processes such as developmental stages, social and task functions, and creative problem solving as well as having the skill to communicate effectively with colleagues and support staff, both orally and in writing.

- **Interprofessional Teamwork** This included being able to facilitate interprofessional case conferences, meetings, team working and networking as well as being able to describe one’s roles and responsibilities clearly to other professionals and discharge them to the satisfaction of others.

- **Diversity** This included being able to tolerate differences, misunderstandings, ambiguity, shortcomings and unilateral change in other professions as well as to be able to celebrate differences and recognize similarities of team members, clients, families, and communities.

- **Ethical Practice** This included developing skills in establishing a mutually trusting relationship as a team as well as being able to apply and integrate ethical principles with team values.

- **Critical Thinking/Clinical Reasoning** Relative to each student’s discipline, this included exploration of genetics, aetiology, epidemiology and pathophysiology of the disease/injury of the client under the team’s care, as well as developing skills in interdisciplinary assessment, intervention, evaluation, and service co-ordination.

- **Research** This included sharing of relevant research articles and critiquing results as a team, being able to evaluate the effectiveness of their interventions, and discussion with the team.

In addition to discipline-specific work, the students were required to complete a number of IRPbc assignments meant to facilitate the acquisition of interprofessional skills and attitudes. While some portions of the work were completed individually, the majority of the assignments were team projects within which everyone was expected to contribute fully. Given there were different start and end dates for the students, this was at times a complicated process. In order to work on the assignments the
students met together as a group for a minimum of three hours a week. This was a mandatory meeting for all team members on placement. The students were asked to complete daily entries into individual learning journals throughout the course of their placement. Within the journal the students were expected to summarize insights and thoughts regarding interprofessional practice, interaction, conflict or collaboration.

Assignments included:

- **Team Community Project** The team, in consultation with appropriate members of the community, were to identify, design and implement a project of relevance to the local community.

- **Case Presentations/Clinical Rounds** All students were expected to do a formal case presentation to their interprofessional team at least once during their placement. Using a client or relevant practice issue, each team member conducted a case conference for 30 minutes which included relevant background, an analysis of the situation from the specific discipline perspective, interventions used to date and questions/practice dilemmas that require peer consultation.

- **Team Rules, Roles and Rituals Exercises** Prior to the commencement of the placement team members were expected decide upon any required group rules and roles that will guide the interaction of the individual and collective team experience.

- **Shadowing** Each student was expected to shadow at least two other students and/or healthcare professionals from a discipline other than their own for at least two hours during the course of the placement. The shadowing was intended to provide the student with the opportunity to gain a deeper understanding of the roles and responsibilities of other disciplines.
**Preceptor orientation and support**

A one-day IRPbc preceptor orientation was provided onsite in four of the five community sites. These were facilitated by the IRPbc Placement Coordinator and a fieldwork coordinator from a post-secondary institution. The latter was involved to foster greater interaction between rural health practitioners and faculty.

The preceptor orientation focused on the goals of IRPbc, interprofessional student team learning within the respective community, and generic preceptor concepts.
Community supports and contributions

Each of the rural communities has provided significant support to the planning, implementation and evaluation of the program by creating a warm welcome and supportive environment for students. In particular, the IRPbc has benefited from:

- A “lead coordinator” who directs/champions the program within the respective community/health organization and participates on the Implementation Team. Typically, this person is a hospital administrator or physician.
- A designated “administrative coordinator” who is the conduit for information, coordination, resolving scheduling and other administrative issues, etc.
- Health professionals who have preceptored students from their own discipline and provided a range of learning opportunities for other students – individually and as a team.

IRPbc has provided financial support to participating communities for the following items:

- **One-time education infrastructure**, particularly related to ensuring student access to information technology (e.g. computers, LCD projectors)
- **Community coordination** to offset costs for the administrative workload related to IRPbc
- **Student accommodation** which typically includes fully furnished suites or apartments close to the hospital.
- **Travel** for lead coordinator or other health professionals to attend planning sessions, international conference on interprofessional education, and orientation sessions in Vancouver.
- **Preceptor support** e.g. library resources, other
- **Student activities** such as a welcome dinner or education session with preceptors.
- **Ongoing linkage** with the respective communities through site visits, telephone, and email
Planning Sessions

Three one-day provincial planning sessions have been held: April 2003, September 2003 and May 2004. The latter was scheduled adjacent to the international interprofessional conference *All Together Better Health* held in Vancouver, in order for IRPbc participants to take an active role in presentations and posters at the conference, as well as learn more about interprofessional education initiatives nationally and internationally.

The purpose of each of these sessions varied related to the stage of the program, but essentially they were designed to foster face-to-face interaction among key participants in the IRPbc, to plan the program and review the progress.

Participants in the planning sessions were primarily Implementation Team members but also included students, health authority and government representatives to broaden knowledge of and input to the program.
**Provincial Coordination**

An experienced Project Coordinator (Ms. Kathy Copeman-Stewart) was assigned to lead the coordination and administration of this program. BCAHC has played a provincial facilitative role in bringing together the respective partners from rural communities, health authorities, post-secondary institutions and government to plan, implement and evaluate the Interprofessional Rural Program of BC.

Processes such as the overall workplan and timeframes, Implementation Team meetings and follow-up, selection of communities and students, communications, etc, have been administratively supported through the BC Academic Health Council.

It has been a challenge to coordinate across the number and range of organizations, particularly given the multitude of issues relating to student placements. However, we were able to build on existing partnerships, resources and activities of the BC Academic Health Council. The Program has significantly benefited from the richness of the input from many different perspectives.

The BC Academic Health Council has provided staff/consultants for a number of roles – program management, placement coordination, administration, financial, and other.
### Sustainability Budget

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<thead>
<tr>
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<th>4 sites</th>
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<tr>
<td>- Travel</td>
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<td>$5,000/team</td>
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<td><strong>Student travel</strong></td>
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<td>$500/student</td>
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<td></td>
</tr>
<tr>
<td>($2,000/community)</td>
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<td></td>
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<tr>
<td><strong>Coordination</strong></td>
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<td>- Student selection/orientation/debrief</td>
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<td>- Liaison</td>
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<td>- Communications (website, other)</td>
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<td><strong>Total</strong></td>
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Communication and Dissemination

A communications plan was developed at the outset of the program. Key communication vehicles have included:

- Website developed and continually updated at [www.bcahc.ca/irpbc](http://www.bcahc.ca/irpbc)
- Periodic newsletters or articles focusing on perspectives from students, communities and post-secondary institutions have been distributed by the BC Academic Health Council, the respective health authorities and post-secondary institutions
- Presentations provided to a number of audiences and by a number of Implementation Team members.
- Newspaper articles locally, radio (locally and nationally)

In addition, there has been significant leadership by students, faculty and community representatives to disseminate information about the program through journal articles, interviews and conference presentations (nationally).

In the summer 2003 the student team from Hazelton presented to the Minister of Health Planning about their experiences, and then almost a year later provided the keynote address to over 400 people at an international conference!
Evaluation

METHODOLOGY

It should be noted that there are limitations to the evaluative methodology chosen for this program. Given the time restraints created by the rapid launch of the program there was insufficient time to develop the quantitative measures that would have provided ‘proof’ of change in the participants. The evaluation team was unable to locate within the professional and academic literature existing measures that would have provided the accuracy needed to measure the desired outcomes. The only option this left was to use a qualitative method of gathering information. A formative method of evaluation was chosen in order to have a continuous feedback loop throughout the various phases. This was important so that improvements could be made to the various program processes as the team determined what was working and what need to be changed. It provided an effective means of quality improvement but added to the problems of outcome measurement as few components of the program remained static over time.

All students (with the exception of some of the medical students who did not consider themselves program participants) took place in the individuals and/or the debriefing sessions held at the end of each phase. The interviews were conducted by members of the evaluation team and followed a set of common questions. Most of the interviews were audio-taped and transcribed although a number in the first phase were recorded by hand. Preceptors and local administrators were also interviewed as part of the evaluation process.

In order to achieve at least a rudimentary degree of quantitative measurement a program logic model was chosen to match program goals to specific outcomes. While this method does not provide proof of change it does allow for the summarization of achievement.

SUMMARY OF THE PROGRAM LOGIC MODEL OUTCOMES

The full IRPbc Logic Model is attached to this report. This section will provide a summary of the outcomes of the program. As mentioned, 62 students from 11 different health disciplines representing eight post-secondary institutions participated in the program. In total during the three phases of the program there were 12 students teams placed in five separate communities. The program ran in four of the health authorities. This is the first time this degree of collaboration has occurred in British Columbia across such a range of partners. As can be appreciated, this in itself is a major accomplishment and speaks of the recognition throughout the province of the need for interprofessional education and practice opportunities.

The program can be deemed successful in a number of areas. For example the program expanded the training opportunities for students across a number of disciplines. In all communities, there have been new placements for health professions not traditionally placed in the community. There has also been involvement of health professionals who had not previously preceptored students. This is important not only because it introduces students to the possibility of rural employment but because it helps to address the shortage of placement sites currently being experienced by many professional programs across the province.
Each phase of the program has been able to involve post-secondary institutions and health disciplines that had not taken part in previous phases.

As expected, the program also contributed to the understanding by students of the unique needs of rural communities. It increased the knowledge of the students of the benefits of interprofessional practice. All of the students reported that they had an increased knowledge and appreciation of not only the role of their own professions but also of those with whom they worked. This occurred through their participation in the student orientation, the weekly team meetings and the shadowing the students did with other team members and/or community professionals. All communities reported increased shadowing opportunities with preceptors from other disciplines. Students in three of the communities were provided ongoing opportunities for mentoring by local physicians.

The students appeared to have contributed to the well-being of the communities in which they were placed. Not only did they provide additional service to the communities while in their placements but each of the 12 teams also completed community projects. The projects varied widely but often included the development of health promotion materials for use by community members. In addition many of the students have been involved in the dissemination of information regarding the program and interprofessional practice. Students have completed presentations at a number of local, national and international conferences. Students have also taken part of a number of media interviews in the local media in the community and in professional newsletters. One student was interviewed on a national radio show.

A further benefit of the program appears to have been the building of community capacity through the inclusion the local professions in the planning and implementation of all components of the program. Health professionals from a range of health disciplines in each of the communities have been involved with the implementation team, planning sessions, orientation sessions, poster presentations at international conference and evaluation.

a) Benefits to the Students

Students identified a number of benefits that they received by taking part in the IRPbc experience. Some of the benefits were discipline specific. The program offered them a chance to become better practitioners in ways that may not have been possible in an urban center. The rural health care centers offered a wider range of learning opportunities than most students would find in an urban placement.

“(The best part was) being in a small hospital and able to use all of my nursing knowledge. I was also able to participate in activities I would not have been able to in the city, such as the treatment of emergency room patients”.

“Well I had initially thought that going up there would be a lot slower paced, which was totally off base (laughter) on my part, cause it was crazy busy. So I don’t think there’s really any cons for going up there, like I saw a lot more patients than I think I would’ve down here, a lot broader spectrum like I already said, yeah like our patient load was just so high that I saw so much that I don’t think it would have been the same down here, just the volume that I would’ve seen”.

“...”
Students also identified that they benefited from their experience in the program through the exposure to other health and human service disciplines. They clearly developed an appreciation of the role and contribution of other professions. The power of this learning should not be underestimated. Indeed, through this and other similar endeavors we may be laying the foundation for significant systemic change.

“I guess (my participation in the program really) opened my eyes to how much knowledge everybody holds...I think I have a new respect of how much knowledge everyone else holds and how important it is...(and) how many resources are there if you are willing to ask and how you have to know what they know in order to make use of their knowledge...I guess the other big learning experience was just in learning how to respect what we all bring to the table and how we all have different approaches. Each discipline has a different approach to seeing a patient or seeing a client and when we piece it all together it can be a very powerful...healing experience...”.

It is apparent that students increased their knowledge and deeper appreciation of their own professions by interacting with students and professionals from other disciplines.

“(Being able) to teach them about my profession allowed me to better understand it first of all, and, um, just get a better understanding of how I fit into that whole team atmosphere in the hospital setting”.

“Over the summer I learned that I really love nursing and am very happy with my choice of professions. I like how my profession fits into the equation and the actual job and think it’s the best fit for me as a person. I also learned that what I really value is simple things like being surrounded by great people and beautiful scenery and that I don’t miss city life at all. Because of this I’ll keep nursing with a smile and I’ll keep rural practice in the front of my mind”.

One of the ways participation in the program helped the students develop an appreciation of other professions was through the breaking down of traditional stereotypes. It is through this process of understanding others that the health and human services areas will become more efficient and effective as professionals learn when and how to access support.

“This is probably one of the most significant pieces of learning for me personally and professionally. I went into the placement with a lot of preconceived ideas and biases about particularly physicians and getting to see their humanness right, and the fact that they are open to learning and open to suggestions as well, helped break down some of those stereotypes. And it’s encouraged me, I feel much more comfortable and willing to seek them out for consultations

Students were able to gain an appreciation of the lifestyle benefits of living in rural communities. They were exposed to a way of living different from what they had experienced in larger centres.
“The community (was) geographically very beautiful. When I arrived in Smithers but I was astounded when I got off the airplane and just kind of looked around at all the mountains and stuff, which I thought was quite beautiful. But then equally so (was) the drive into Hazelton along the river was just a phenomenal drive and just a beautiful place. We went for a walk my first night when I actually arrived in Hazelton (and......) I was pleasantly surprised at kind of the friendliness of the people that even just on our walk. We stopped down at the river at one point and we were taking some photos and somebody that was just wandering out for a walk, walking their dog or something, stopped and ‘Oh what are you taking, why are you here?’ and started talking to us right away and you know, ‘Do you want me to take a picture of you?’ So it was just kind of that friendly small town sort of atmosphere I found right away”.

Another benefit had to do with acquiring knowledge regarding the unique nature of rural communities. Many students were surprised by the complex health care issues of people in rural settings.

“I was able to learn more about my community and some of the challenges it faces. I also had the privilege of being included in some of the support group meetings for people coping with Long QT Syndrome, an important medical issue for First Nations people in this area”.

Clearly the goal of having students consider working in rural communities was met. In many cases the student participants had no previous exposure to rural communities. They were pleasantly surprised by their experiences.

“(Having a) rural experience was pretty interesting….I would have never ever ever thought about working in a rural setting – ever. And then I took this opportunity and now I would definitely consider it”.

“Since I never lived in a town smaller than Vancouver, I thought that I may have a hard time adjusting to living in a small town. I actually really enjoyed my time in Bella Coola. There was always something to do in the community and people are very friendly and approachable.I learned that I would enjoy living in a small community. I may pursue a rural lifestyle in the near future”.

Another benefit for the students seem to be that they acquired an appreciation of the importance of seeing the patients and clients with whom they work as being people who live in the broader community. While this approach of seeing people of being part of a greater whole is taught in school it is often difficult for students to translate this concept into practice. The IRPbc experience seems to assist in this process.

“So you really see the connectedness of things I think, and that really helped. Cause I think when you’re solely in a program... That’s what the huge thing is, when you’re in a program, you’re with people all the time who are in that program and you’re always talking about those issues and those views and so you don’t see anything else. And even during your school years your personal contacts are often with people
who are in the same sphere as you, so you don’t really get other points of view....”.

“I feel a lot more comfortable working with teams now and also I feel that it’s essential, like I’ve sort of developed this notion that the best way to serve clients is to work as teams and so, you know, that’s what I come out of that with (from the experience)”.

There were benefits to the students that were not just professional in nature. While this type of learning can occur in a number of different settings many of the participants saw their growth as being a result of their participation in the program.

“I mean I could have been treating that person in the clinic and had never known that those issues were happening within that person’s family and you know she gets to see the whole other side of the coin. So I guess maybe the perspective changing is not so much on the professions but that the person that we’re treating is more of a whole person as opposed to a physical disability or a mental disability or anything like that”.

“(In the past sometimes) I keep my opinion to myself in order to avoid conflict but the times that I have opened up it has served the group better. I will speak my mind more freely in team settings in the future”.

“The spirit of the IRPbc program made me look at my practice from a different point of view when interacting with other professionals. I tried to take the time to find out what each person’s role was on all the teams I worked with (during my placement)”.

b) Benefits to the Community

The people connected with IRPbc saw the need to ensure that the program was not just another ‘innovative’ program imposed on rural British Columbia by the Lower Mainland. It was apparent from the beginning that for this program to work there needed to be a true collaboration between all of the partners. This needed to include not just the local health providers but also the community members.

Many of the community professionals saw IRPbc as a means in which they could attract highly competent professionals who would make a significant contribution to their communities.

“(The program) gave the community a sense of ownership of their health care in a sense. They are playing a role in training health care providers. They’ve always had this change with the medical students and the residents but I don’t think it has ever been presented to them as ‘Hey. You have this opportunity to mold health care providers of the future. There’s never been this extension into the community which there has been with IRP’”.

“I strongly believe that northern and rural areas need creative and innovative programs to encourage professionals to consider these
locations as outstanding professional possibilities. IRPbc facilitates that (that process)“.

It has long been known that there are benefits to being a preceptor. However in rural settings there is less of a likelihood that such opportunities will occur. IRPbc provided the opportunity for an increased number of rural practitioners to have the chance to mentor students. The local preceptors also experienced a sense of pride in the work that they did with the students. It was apparent to them that they had a lot to offer the students.

“The IRP (students) were the first students I’ve ever preceptored

“I think (preceptoring) is good because it stimulates the staff who are here because you have students who make you think; “Oh, she asked a question and I’m not quite sure what the answer is…I better start brushing up.” So I think it was great for the staff to have the interaction with the students. I think it kind of makes you step back and start re-thinking things sometimes.

“I got to interact with somebody who’s (currently in) the education system, has fresh knowledge and new insight and (can) update me on where things are happening in the academic world. And she did. And it was wonderful to interact with a young woman who has such self-esteem and such confidence that she could say, “Well, you know, this is what we’re being taught now” and to be able to hear things and to get the feedback, yeah, and appreciate the (learning)”.

While rural healthcare practitioners work hard to stay current in their skills this can be more difficult than in urban settings because of a lack of training opportunities. The students brought fresh perspectives to the communities that in many cases benefited the local staff.

“I think they met those goals of experiencing rural community and experiencing inter-professional work. I think those were real benefits. I think that the social aspect, the social connections/relationships were benefits that will last them into their future. And then for the preceptor, for me. I don’t know. There were personal goals involved: a little bit of confidence building, a little bit more connection, and little bit more (knowledge) about what’s happening out there...I enjoyed my students”.

‘Here, in my own practice, I am working closely with nursing, community nursing, public health nursing, with the nurses for the band, with our social worker here, and the mental health worker here. We support each other; we cover each other's areas to some extent when we’re away”.

Rural settings appear well suited for interprofessional placement opportunities because of the nature of the healthcare settings. Their size and limited number of staff force people to work together in ways that does not often happen in urban centres.
There appear to be other important benefits for the community, although they are not directly part of the mandate of the program.

“There is a little bit of an economic benefit to our community. I know it sounds crazy, but to have six people here who are doing things like taking riding lessons, who are buying groceries, who are going on chartered trips, all that is somehow encouraging to our community. There is more activity. So yeah there are lots of spin-offs.

“I think that this program highlights rural health care. It kind of puts us on the map. It increases the radar for where we are and what we do and how we do it, what we have to work with. As well, these students, when they come into our communities they make friends with the young people in the community. They therefore form connections, rural-city connections. It increases social opportunities for our own local young people because you know, you add five or six or seven young people to a community this size and that’s like a huge infusion of new blood! You know, it’s extra hands to help at community events, particularly in summer, not as much of that in the winter, but goodness they didn’t seem to lack social opportunities”.

Another benefit to the community was the interaction the student teams had with young people in the local school system and recreational functions. Again, while not an anticipated benefit, the IRPbc students served as role models for the young people of the area. The thought in some of the communities is that this may encourage young people from the area to enter health professions in the future.

“They were very successful in putting a positive image over to the community. They went out, as a group, and attended almost every community function that happened over the summer. They presented themselves in a very positive way and the community knew who they were. So this is very good: the community seeing these students and recognizing that they’re gonna be their health care providers in the very near future. So I think it had a, a two-way impact. Both on the students but also on the community – making the community aware. It’s also a connection for students in Bella Coola to see role models very close to the level that they’re in. It was good”.

It is fitting to end this section of the report with a comment form a rural healthcare administrator who summarizes the biggest benefit of IPRbc to her community.

“Rural Canada, rural BC has to compete with urban Canada, urban BC for some very bright people and, of course, we don’t just want anybody, we want people that are skilled. By bringing the kind of mature students that tend to get placed, and if we succeed in interesting them in working in a rural setting that is a huge benefit... for future recruitment”.
Summary of Benefits, Successes and Struggles

Through feedback from students, communities, and faculty and in discussion with the Implementation Team, a number of benefits, successes, and struggles have been identified.

**Student benefits** include the opportunity to work with experienced generalist practitioners across the continuum of care and the chance to interact as part of an interprofessional team. They gain a stronger sense of their own professional identity and develop a stronger understanding of client needs. They also benefit from the experiences associated with rural practice and life in a small community.

**Local health provider benefits** include the energy and ideas of student teams and the chance to increase knowledge regarding interprofessional practice. They benefit from the preceptor training and support in providing health care in the community. Finally, the communities have changed the attitudes of students regarding rural practice and have recruited new staff.

**Post-secondary institutions benefits** include new placement sites for students, greater linkages with rural communities, and the opportunity to see interprofessional learning in action.

The following key factors have contributed to the success of the program:

- **Leadership** on many levels, including the many organizations represented on the Implementation Team, and in particular the local champions who put the IRPbc concepts into action. The implementation team has been vital in implementing the program quickly, keeping the process moving within the short timeframes, enabling communication/interaction across participants and making program changes where required.

- **Strong communities** with a long-standing commitment to health professional education and experienced preceptors who provide a welcoming and supportive learning environment.

- **Interprofessional student team activities** which include the community project, weekly meetings, shadowing, exposure to other professions and the student orientation.

- **Student incentives and support** such as travel assistance, on-site administrative support and shared accommodation.

- **Provincial coordination** by the BC Academic Health Council which facilitates the collaborative processes and ongoing communication across health and education.

One of the key challenges of IRPbc has been how to balance the perspectives across multiple post-secondary institutions, particularly given the central role of University of British Columbia. In many ways it is the elephant in the room that no one can ignore both because of its size and its multiple health professional programs, many of which are the only ones in the province. The program did benefit, especially in the early phases from the leadership in interprofessional education provided through the College of Health Disciplines as well as through interprofessional structures such as the Practice Education Coordinators Committee at UBC.

In addition, nursing perspectives and placements are particularly complex in BC given that the large number of nursing programs in the province, an existing storage of placements and the division of the province into placement areas associated with
particularly institutions. It has been invaluable to have the Nursing Education Council of BC participate in the process, to foster communication with and input from the various nursing programs.

There has also been an internal mandate conflict within the program between the goal of promoting interprofessional practice and the goal of assisting the local communities to recruit healthcare practitioners. If it is on the interprofessional mandate then it does not matter where the students come from but if it is on recruitment then it makes more sense to some that the students come from urban centers. Students from rural post-secondary institutions do not need to be exposed to rural settings as they live in them. They will stay in rural settings or not based on factors not likely to be associated with the IRPbc experience. It is the urban based students who have little or no experience with rural settings that are most likely to change their mind about working in rural areas after exposure to a positive learning experience.
**Recommendations**

1. Maintain existing sites as interprofessional rural education sites
   Minimal investment required with maximum benefits - policies/processes have been established, communities and preceptors across a range of professions have a high level of expertise about program and are able to support the interprofessional teams, accommodation is in place in 3 communities, partnerships with faculty are well established and most importantly, these communities have experienced the benefits and are enthusiastic to continue.

   Note: in order to have summer 2005 placements, student team selection process must get underway immediately.

2. Maintain focus on community-driven process in partnership with post-secondary institutions. Continue to balance dual goals of interprofessional education, and rural recruitment and retention.

3. Consider establishing an interprofessional rural education site with Fraser Health

4. In the next 1-2 years, maintain the central coordination through the BC Academic Health Council

5. Develop a marketing strategy for students incorporating the stories/feedback received from participating students

6. Establish recruitment mechanisms into rural health practice for participating students

7. Consider networking opportunities with former IRPbc students to foster continued interprofessional collaboration and leadership, and assess rural practice interest

8. Establish new evaluation parameters in conjunction with other funding opportunities, such as Health Canada’s funding program for Interprofessional Education for Collaborative Practice and Patient Centred Care (IECP-PC).

9. Use interim bridge funding to establish longer term sustainability with health and education

10. Continue to share lessons learned with respective health authorities/western provinces/other in furthering IECPCP in BC and across Canada.

11. Partner with other provinces to enhance opportunities, share in knowledge generation, and share ongoing administration, coordination, and communication efforts.
IRPbc Statistics

- Five rural BC communities have hosted interprofessional student teams – Bella Coola, Hazelton, Port McNeill, Trail and Fort St. John
- 3 placement phases with 12 student teams – summer 2003 (3 teams), January/February 2004 (5 teams) and summer 2005 (4 teams)
- 62 student participants to date plus other adhoc participants (e.g. medical residents, international medical students) onsite in the respective communities
- 50 students participated in three 2-day student orientation (all students except 2 PT students and medical students) In addition, 9 health professionals/senior administrators have participated in these orientation sessions
- 38 rural health professionals across the five communities have served as primary preceptors for students – many others have mentored students or interacted with individual or student teams on a formal and informal basis.
- 11 professions represented by students and preceptors:
  - medicine
  - nursing
  - social work
  - physical therapy
  - occupational therapy
  - pharmacy
  - speech language pathology
  - audiology
  - counseling psychology
  - medical radiology
  - medical laboratory
- 8 post-secondary institutions involved to date
  - University of British Columbia (medicine, nursing, OT, PT, audiology, speech language, social work, pharmacy, counseling psychology)
  - British Columbia Institute of Technology (medical radiology, medical laboratory)
  - University College of the Cariboo (nursing, social work)
  - University of Victoria (nursing)
  - Selkirk College (nursing)
  - Malaspina University College (nursing)
  - North Island College
  - Okanagan University College (now UBC Okanagan – social work)
- About 50 health professionals have participated in preceptor orientation (5 one day sessions) - “usefulness of session” rated to be 4.6 and 4.3 out of 5.
- Over $25,000 invested in education infrastructure e.g. computers, software, LCD projectors, library books, other
- Website created with xx “hits” per month
Over 120 people - representing mayors, aboriginal and other community leaders, senior health administrators, post-secondary institution deans and faculty, hospital board members, media, health professionals – have been briefed on the program through site visits to the five rural communities.

Three 2-day orientation sessions have been held – attended by 16-18 students each. Three one day provincial planning sessions have been held with Implementation Team members as well as other key participants including students, health authority representatives and government.

Dissemination activities undertaken by numerous participants including students, faculty, health authorities and BCAHC – international conference (keynote address by Hazelton student team, 4 posters, 1 presentation), national conferences, professional journal articles, newspaper articles, newsletters (BCAHC, College of Health Disciplines, health authorities), television and radio interviews (1 national, 1 provincial and numerous local), various presentations to Minister of Health Planning/senior executive/regional boards.

Eight students/graduates have returned to rural communities for locum/clerkships or permanent positions – social work (Port McNeill), nursing (Bella Coola/Hazelton, Hazelton), speech language pathologist (Hazelton/Terrace), pharmacy (2 Bella Coola), medical laboratory (Port McNeill) and one nurse to the Yukon.

Presentations
- Minister of Health Planning by Hazelton team
- Nursing (3 nursing graduates plus faculty) – western Canada conference
- Physiotherapy national conference
- Social work national conference
- International conference – keynote address by 5 students on Hazelton team
- International conference – 4 posters developed (program overview, student/faculty and rural community perspectives, evaluation themes, Trail) with input from students, faculty, rural communities, BCAHC.
- International conference presentation with participation of rural communities, faculty and BCAHC
- Student team presentations to UBC nursing, OT/PT, College of Health Disciplines
- UBC social work students presentation to scholars from Viet Nam
- Student team presentations at IRPbc planning sessions (2) and student orientation
- C&W education committee
- Deans and Directors of Health Sciences
- Western Provinces

Professional journal articles
- TUFT
- PT national journal
- Nursing provincial
- Social work underway
- Media interviews/articles
- Pharmacy in national journal
- CBC national radio
- Vancouver Province
- Numerous local newspapers in all the communities
- UBC Reports
- College of Health Disciplines newsletter
- Prince George television
- UBC School of Social Work newsletter
- Newsletters of health authorities - Vancouver Island, Northern Health, Vancouver Coastal, Interior Health
Program Logic Model
### Program Logic Model

#### [LT outcome – intended impact]

**BC rural communities will have enhanced health care services**

<table>
<thead>
<tr>
<th>M/T outcomes - action</th>
<th>1. BC rural communities will experience an increase in collaborative <strong>service delivery</strong> amongst health professionals</th>
<th>2. BC rural communities will experience an increase in collaborative <strong>partnerships</strong> between health service providers and PSEs</th>
<th>3. BC rural communities will increase the number of health professionals <strong>recruited and retained</strong></th>
<th>4. BC rural communities will experience increased <strong>access</strong> to a broader range of health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>[S/T outcomes – immediate accomplishments]</td>
<td>1.1 Students will demonstrate increased competence to practice in interprofessional teams</td>
<td>2.1 Rural communities will have increased capacity for student placements</td>
<td>3.1 Communities will host students from a wide variety of health professions, exposing them to rural life and practice</td>
<td>5.1 Rural communities will have increased capacity for service delivery</td>
</tr>
<tr>
<td>1.2 Communities will have more collaborative practice among health practitioners</td>
<td>2.2 Health professionals in rural communities will have increased preceptor confidence</td>
<td>3.2 Rural communities will experience an increase in their pool of health professionals to recruit.</td>
<td>5.2 Communities will have enhanced consultation and referral mechanisms</td>
<td></td>
</tr>
<tr>
<td>1.3 There will be advancement of knowledge of interprofessional theory in education and practice in BC</td>
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<tr>
<td><strong>Note</strong>: Outcomes should benefit the client i.e. BC rural communities, not the system</td>
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</tbody>
</table>

**Program inputs**

- Community infrastructure and support
- Mechanisms for communication and networking
- Student incentives and support
- Provincial coordination
- Evaluation
Program Logic Model

Program inputs/resources

- Community infrastructure and support
  - Coordination
  - Preceptor training
  - Computers
  - Student housing
  - Travel for provincial planning sessions
  - Other

- Student selection, incentives and support
  - Travel
  - Orientation
  - Other

- Mechanisms for communication and networking
  - Implementation team
  - Provincial planning meetings
  - Website
  - Other communications

- Provincial coordination
  - Staffing

- Evaluation

Note: Inputs common across all outcomes
<table>
<thead>
<tr>
<th>Short term outcomes</th>
<th>Outcomes</th>
<th>Activities</th>
<th>Indicators of Success</th>
<th>IRPbc Results</th>
</tr>
</thead>
</table>
| 1.1 Students will demonstrate increased competence to practice in interprofessional teams | ▪ Student orientation curricula  
▪ Team assignments  
  o Team project  
  o Team meetings  
  o Shadowing  
  o Journal  
  o Team rituals | ▪ Develop and implement student orientation curricula  
  ▪ Develop student assignments e.g. team meetings, shadowing, journal, team rituals | ▪ 90% of students participate in student orientation  
  ▪ 100% students self-report increased knowledge of other professions as indicated through debriefings & interviews  
  ▪ 100% teams undertake and complete team project  
  ▪ 100% of students will complete required assignments  
  ▪ Students collaborate in providing presentations and/or publications about their IRPbc experience  
  ▪ 90% students report a desire to continue to be involved with interprofessional activities after return from IRPbc experience | ▪ 80% (50 of 62) students participated in student orientation.  
  ▪ Excluding medicine, 96% students attended. (no medical students have participated to date due to conflict with examinations, and communication)  
  ▪ 100% of students who participated in interviews and/or debriefings reported increase knowledge of other professions  
  ▪ Each of the 12 student teams has undertaken and completed a community team project  
  ▪ 100% of students completed 2 or more of the required assignments  
  ▪ Numerous Presentations, professional journal articles and media interviews/articles – locally, provincially, nationally and internationally – by students, rural communities, faculty and BCAHC/IRPbc |
| 1.2 Communities will have more collaborative practice among health professionals | ▪ 34 health professionals across the 5 communities and representing 11 different professions have been primary preceptors for IRPbc students | ▪ Plan and implement preceptor orientation including IPE guiding principles/competencies and student assignment information  
  ▪ Place teams of students representing range of health professions into rural communities  
  ▪ Develop student objectives & assignment which foster and acknowledge collaborative practice | ▪ Communities report an increase in the number and range of health professionals interacting with students  
  ▪ Local physicians take an active role in mentoring students from various disciplines  
  ▪ Health professionals representing a range of professions take an active role in planning, implementing and evaluating the IRPbc  
  ▪ Communities report changes relating to collaborative care as a result of hosting students | ▪ In all communities, there have been new placements for health professions not traditionally placed in the community.  
  ▪ In all communities, there has been involvement health professionals who had not previously preceptored students  
  ▪ All communities reported increased shadowing opportunities with preceptors from other disciplines.  
  ▪ Students in 3 communities were provided ongoing opportunities for mentoring by local physicians  
  ▪ Health professionals from a range of health disciplines in each of the communities have been involved with  
    o Implementation Team  
    o Planning sessions  
    o Orientation sessions  
    o Poster presentations at international conference |
<table>
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<th>Activities</th>
<th>Indicators of Success</th>
<th>IRPbc Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 There will be advancement of knowledge of interprofessional theory in education and practice in BC.</td>
<td>• Development, implementation and evaluation of IRPbc</td>
<td>• Establish Implementation Team and actively involve participants in development of IRPbc</td>
<td>• 80% of participating communities and PSEs indicate willingness to continue to participate in and build on program</td>
<td>• 4 of 5 (80%) communities hosted student teams more than once, and indicate commitment to continue</td>
</tr>
<tr>
<td></td>
<td>• Range of organizations from health and education represented on Implementation Team</td>
<td>• Host provincial planning sessions with health authority and other key partners</td>
<td>• 100% of program participants report increased knowledge regarding interprofessional education and practice</td>
<td>• 100% of program participants report increased knowledge regarding interprofessional education and practice</td>
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<tr>
<td></td>
<td>• Summary reports from 3 planning sessions</td>
<td>• Undertake community site visits to meet with health professionals and community leaders</td>
<td>• Evaluation report disseminated to stakeholders</td>
<td>• Evaluation report to be disseminated to stakeholders in BC after acceptance by Implementation Team</td>
</tr>
<tr>
<td></td>
<td>• Number of people engaged in community meetings and range of stakeholders (over 120 representing senior management of health region, aboriginal groups, mayors, post-secondary institutions, hospital board, health professionals, media)</td>
<td>• Provide preceptor training</td>
<td>• Number/range of people who participate in posters and conference presentations</td>
<td>• Over 40 individuals (students, health professionals from rural communities, academics, BCAHC) have participated in presentations or posters regarding IRPbc – many of these have presented more than once</td>
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<tr>
<td></td>
<td>• Number of health professionals (50) receiving preceptor training</td>
<td>• Undertake literature search and summarize lessons learned from other jurisdictions</td>
<td>• Number of poster and conference presentations</td>
<td>• Presentations, journal articles, interviews, newspaper articles, other</td>
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<td></td>
<td>• Background reports – Strategic Directions for</td>
<td>• Disseminate knowledge about interprofessional education and practice</td>
<td>• Number of articles written and published</td>
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<tr>
<td>Short term outcomes</td>
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<td></td>
<td>IRPbc &amp; IPE, Annotated bibliography</td>
<td>Identify community champions</td>
<td>100% of communities willing to host again</td>
<td>80% of communities have hosted more than once</td>
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<tr>
<td></td>
<td></td>
<td>Undertake site visits &amp; meetings</td>
<td>80% of preceptors willing to precept again</td>
<td>No preceptors have reported an unwillingness to precept again</td>
</tr>
<tr>
<td>2.1 Rural communities will have increased capacity for student placements</td>
<td>Number of rural communities (5) hosting students</td>
<td>Provide community funding for coordination, housing, other and evaluate needs for the future</td>
<td>Number of students completing placements</td>
<td>100% (62) students completed the placements</td>
</tr>
<tr>
<td></td>
<td>Number of PSEs (8 to date) placing students</td>
<td>Undertake preceptor interviews</td>
<td>Number of types of professions not previously/typically placed in communities</td>
<td>Types of professions not previously placed</td>
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<tr>
<td></td>
<td>Number of different professions placing students (11 to date)</td>
<td>Provide travel subsidy and housing to students</td>
<td></td>
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<td></td>
<td>Number of students (62) participating</td>
<td>Organize planning sessions (3)</td>
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<tr>
<td></td>
<td>Number of preceptors (38 primary preceptors – many others have interacted with and mentored students)</td>
<td>Provide preceptor training (1-day session)</td>
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<tr>
<td></td>
<td>Computers (4), LCD projectors (2) and other education infrastructure</td>
<td>Lit search, background documents w/key concepts</td>
<td></td>
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<tr>
<td></td>
<td>Number of preceptors (50) trained</td>
<td>Developed selection criteria for communities &amp; students</td>
<td></td>
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<tr>
<td></td>
<td>Housing</td>
<td>Recruit PSEs</td>
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<td>Develop communication messages &amp; vehicles</td>
<td></td>
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<tr>
<td>2.2 Health care professionals representing a range of disciplines in rural communities will have increased knowledge and confidence regarding preceptoring</td>
<td>Number of preceptors involved</td>
<td>Provide preceptor training</td>
<td>Increased number of health professionals preceptoring students</td>
<td>Many of the participants in the preceptor orientation sessions had not previously had preceptor training (Fort St. John, Bella Coola)</td>
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<tr>
<td></td>
<td>Number of preceptors trained</td>
<td>Develop processes for preceptor support &amp; recognition</td>
<td>Preceptor feedback from orientation sessions</td>
<td>Participants rated usefulness of preceptor orientation 4.5 and 4.3 out of 5</td>
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<td></td>
<td>Number of preceptors who met with Program representatives</td>
<td>Increase networking of fieldwork coordinators with respective health professionals</td>
<td>Preceptors willing to host students for future placements</td>
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<tr>
<td>Short term outcomes</td>
<td>Outcomes</td>
<td>Activities</td>
<td>Indicators of Success</td>
<td>IRPbc Results</td>
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| **3.1 Communities will host students from a wide variety of health professions, exposing them to rural life and practice** | - Number of students preceptored                                          | - Liaise with fieldwork coordinators from variety of programs & PSEs to foster involvement and input  
- Provide student incentives  
- Develop student selection processes that focus on community needs  
- Encourage students to document and share their experiences | - Increasing number of participating schools and programs with each set of placements  
- Types of students placed meets community needs as identified in selection process  
- Students/schools contacting IRPbc with interest in program | - Each phase of IRPbc has had introduced new programs and schools (e.g. Phase 2 – Malaspina, North Island, UVic, BCIT medical radiology, OUC social work and Selkirk nursing, UBC counseling psychology  
- Phase 3 UCC social work, audiology,  
- 11 health professional programs involved  
- Rasonable success to recruiting health professions requested by communities except for dentistry, nurse practitioner, psych nursing, health records  
- 8 PSEs involved  
- Fieldwork coordinators from a variety of professions and BCAHC report a significant increase in information regarding student placement opportunities through IRPbc |
| **3.2 Rural communities will experience an increase in their pool of health professionals to recruit** | - Students enthusiastic about rural life and practice, and interested in returning  
- Stories/experiences shared informally and formally e.g. presentations | - Communities actively recruit/hire graduates on locum or full-time basis  
- Communities seek innovative ways to create locum/permanent positions to recruit IRPbc students/grads  
- Contact site coordinators and post-secondary contacts to determine graduates hired in rural communities | - Number of graduates that return for locum or full-time positions | - This indicator can only be measured over the longer term although 3 74 graduates have returned for locum and/or permanent positions  
- Communities report interest to recruit students, however, vacancies are not available at this time |
| **3.3 Rural community health professionals will have linkages with larger centres & PSEs.** | - Number of community site visits by faculty  
- Faculty appointments | - Provide preceptor orientation which includes teamwork exercises  
- Promote greater interaction of health professionals with faculty e.g. through site visits, email, other  
- Provide opportunities for | - Communities/faculty self-report greater linkages | |
### Short term outcomes

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<tr>
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<tbody>
<tr>
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<td>networking and continuing education e.g. through planning sessions, international conference, other</td>
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4.1 Rural communities will have increased capacity for service delivery

- Number of clients receiving service
- Team project undertaken/completed by each team

- Select senior level students able to provide direct care and be self-directed where appropriate
- Students provide client care
- Students undertake team project based on community priority/need

- Communities report increased number of clients seen and/or decreased waiting lists/other
- Team project reported to be well received and/or be followed up by community or health professionals.

4.2 Rural communities will have enhanced consultation and referral mechanisms

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Longer term